CMS Informal Waiver Review Questions

Rate Setting

Appendix C-4 Additional Limits of Amount of Waiver Services

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 38.e & 57.a. Please specify if there is a maximum dollar amount for individuals on this waiver. Please specify when individuals are notified in writing regarding the amount of the limit.
  - 38.d & 57.b. Please specify whether additional funding requested through the exception process is temporary and/or permanent adjustment in funds to the budget.
  - 38.c & 57.c. Please specify whether geographic factors affect the budget amount.
  - 38.d & 57.d. Please clarify the process when a participant is referred to another waiver. What happens if the other waiver has a waiting list? Does the referred participant have priority status to access the waiver and its services?
  - 38.f & 57.e. Please explain for CMS' understanding why the methodology for determining an individual budget is not open for public inspection.
- Adult Day Waiver Only
  - 38.a. Prospective Individual Budget Amount – Please specify if there is a maximum dollar amount for individuals on this waiver. a. Please specify when an individual's service coordinator informs the individual of their budget amount and can the individual request to review the budget amount.

Appendix I-1 Financial Integrity and Accountability

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 54 & 73. Why provider claims only audited in response to concerns are raised by complaints or certification or licensure reviews? What other procedures does the state use to ensure financial integrity and accountability of provider claims.
  - 55 & 74. DD agency providers are required by contract to do an annual audit of their operations. Specifically, are the auditors required to be independent of the agency? If not, why not?
  - 56 & 75. Please explain, in detail, what procedures are in place to monitor the financial integrity and accountability of claims made and paid. Specifically, other than reviewing claims for cause, what steps does the state take to ensure that claims match the plan of services, that providers are duly authorized to perform the indicated services, that the services were properly performed on the dates indicated by the person indicated, in accordance with the plan of services? If random samples of claims are used, please specify the source of the population, how the sample is selected, who performs the review, how are the results reported, and what happens when defects are identified?

Appendix I-1 Financial Integrity and Accountability (continued)

Questions asked of:

- Comprehensive Waiver Only
  - 76. Please clarify how services are reviewed to ensure fiscal integrity, by explaining, in detail:
    - f. Whether the review is performed pre- and/or post-payment.
    - g. For each type of review of service claims, is the review a true independent audit?
    - h. Who performs each type of review?
    - i. How frequently are each of these reviews performed?
    - j. How are service claims selected for review?
    - k. How many claims are reviewed for each period specified?
    - l. What documents or data is examined for the review?
    - m. What data elements are reviewed?
  - 77. Explain the review methodology in detail, for example, include in your explanation:
    - n. How does the reviewer determine that a particular claim for service was performed during the period authorized by the plan of care, in the amount, type, and whether the appropriate provider specified by the plan of care.
    - o. How does the reviewer determine whether the participant was in an setting eligible for personal care services (e.g., the participant was not in a hospital or nursing facility)?
    - p. How does the reviewer confirm that the individual providing the personal care services is eligible and qualified to provide such services?
  - 78. What corrective or other steps are taken when errors are found?

Appendix I-1 Financial Integrity and Accountability (continued)

Questions asked of:

- Comprehensive Waiver Only
  - 79. Please explain, in detail, the systems and procedures in place to assure that:
    - (i) personal care services are provided only by qualified individuals;
    - (ii) such individuals only provide the services to eligible participants with the frequency, amount, and duration specified in the plan of care; and
    - (iii) such individuals are only paid for the services they actually perform that are in accordance with the plan of care.
  - 80. Please explain, in detail, how the systems and procedures described in B (above) check for and detect:
    - (i) services that are billed for but not actually rendered;
    - (ii) duplicative billing (i.e., either billing more than once for the same service or billing by more than one individual or agency for the same service provided to the same individual); and
    - (iii) services provided by an unauthorized individual and either billed by the unauthorized individual or by an authorized individual.
  - 81. Please explain, in detail, what monitoring systems and procedures are used to detect and prevent participants from being coerced into approving services that were not provided in accordance with his or her plan of care, or were not provided by an authorized provider.

Appendix I-1 Financial Integrity and Accountability (continued)

Questions asked of:

- Comprehensive Waiver Only
  - 82. What specific organization is accountable for the proper administration of the systems and procedures described in B (above), and what does the state Medicaid agency do to monitor the organization accountable for fiscal integrity?
  - 83. What procedures are in place to ensure that providers satisfy all applicable qualifications for performing personal care services, both before and during their provision of services?
  - 84. What procedures are in place to ensure that ineligible providers cannot and do not provide personal care services and that they cannot be paid for those services if they do provide such services?
  - 85. Explain what corrective actions that are taken if and when errors are found. Include procedures for notifying the operating agency, the state Medicaid agency, and other agencies responsible for combatting fraud, waste, and abuse.

Appendix I-2a Rate Methodology

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 57 & 86. General questions for all service rates:
    - q. Please describe the processes in place to ensure the rates are sufficient to enlist enough providers.
    - r. Have there been shortages of any types of providers? If so, what steps have been taken to ensure adequate staff are available in those areas of shortage?
    - s. Please describe the processes in place to ensure the rates are sufficient for the program to attract and retain persons who provide high quality of care.
    - t. How frequently are the rates updated?
    - u. When was the last time that these rates were updated (i.e., rebased)?
    - v. Can these rates be adjusted retrospectively and, if so, what processes are in place to do so?
  - 57 & 87. The waiver states the rates for Respite services and Community Living and Day Supports (CLDS) delivered by independent providers are based on usual and customary rates for independent providers funded through other DHHS programs.
    - w. Describe how the information from those programs was used in the rate development, were the rates blended, adjusted or simply accepted to be appropriate for the waiver services.
    - x. Please describe any adjustments (e.g., Unit Cost Trends, Utilization Trends, Risk Difference for the two populations) applied to the rates from other programs in developing the rates for the new services.
    - y. Are the guidelines that DHHS issues for the rate ranges required to be strictly followed? How is it assured that these guidelines are followed?

Appendix I-2a Rate Methodology (continued)

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 57 & 86. General questions for all service rates:
    - q. Please describe the processes in place to ensure the rates are sufficient to enlist enough providers.
    - r. Have there been shortages of any types of providers? If so, what steps have been taken to ensure adequate staff are available in those areas of shortage?
    - s. Please describe the processes in place to ensure the rates are sufficient for the program to attract and retain persons who provide high quality of care.
    - t. How frequently are the rates updated?
    - u. When was the last time that these rates were updated (i.e., rebased)?
    - v. Can these rates be adjusted retrospectively and, if so, what processes are in place to do so?
  - 57 & 87. The waiver states the rates for Respite services and Community Living and Day Supports (CLDS) delivered by independent providers are based on usual and customary rates for independent providers funded through other DHHS programs.
    - w. Describe how the information from those programs was used in the rate development, were the rates blended, adjusted or simply accepted to be appropriate for the waiver services.
    - x. Please describe any adjustments (e.g., Unit Cost Trends, Utilization Trends, Risk Difference for the two populations) applied to the rates from other programs in developing the rates for the new services.
    - y. Are the guidelines that DHHS issues for the rate ranges required to be strictly followed? How is it assured that these guidelines are followed?
  - 57 & 88. Were trend rates applied separately for both utilization and unit cost adjustments?
    - z. If so, please provide each of the trends for all services.
    - aa. If not, please provide the trends for each waiver service and explain why it is suitable to only use a single trend for each service and not separate utilization and cost trends

Appendix I-2a Rate Methodology (continued)

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 59 & 89. Please clarify if the rates vary by geographic region, if so please describe how the rates were determined by geographic region.
  - 62 & 91. Please explain the justification for the adjustment factor for ICE 110 percent and vocational planning 105 percent. What was the factor?
  - 63 & 92. Please explain how 15/10 percent were determined to develop the supported integrated employment rate
  - 60 & 93. Was there any change in rate methodology since the last renewal or amendment? If so, please describe all changes and the reasons for those changes.

Appendix I-2a Rate Methodology (continued)

Questions asked of:

- Adult Day Waiver Only
  - 58. Please provide a more specific link or instruction of which report identifies the waivers' rate study.
  - 61. Please specify whether base rates begin at the state, federal, or other minimum wage.
  - 64. Please remove language regarding behavioral/medical risk since these are not services provided under this waiver.
  - 65. Please explain why the retirement service rate for reimbursement is below the state's minimum wage.
  - 66. Please specify the entity or entities responsible for all rate determinations and how the process is conducted.
  - 67. Please specify how and when the rates are adjusted.
- Comprehensive Waiver Only
  - 90. Please clarify if the rates for the same services vary by provider, and if so, please describe how the rates vary by provider.

Appendix I 2d.- Billing Validation Process

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 68 & 94. Does the state use patient surveys to validate post payment billings? If yes, please describe those methods. If not, describe what processes are in place to assure only proper payments are being made and that any payments for inappropriate billings are recouped.
  - 69 & 95. Does the state use a post-payment audit as part of the billing validation process? If so, what processes are in place to assure only proper payments are being made and that any payments for inappropriate billings are recouped?

Appendix J-Tables

Questions asked of:

- Adult Day Waiver Only
  - 70. The rates of reimbursement will need to be revised to separate the distinct services as identified in Appendix C and for varying levels of service.

Appendix J-2a and J-2b Unduplicated Participants and Average Length of Stay (J-2b)

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 71 & 96. Were lapse rates (rate of participants leaving the program) built into the projection of the unduplicated participants? If so, please provide the rate and describe how it was developed. If not, describe why no rate was built into the projection.
  - 72 & 97. Please explain why the population is projected to increase in each year of the renewal.
  - 73 & 98. Please explain why the ALOS is expected to remain constant for all five years of the waiver.

Appendix J-2c: Development of Factor D

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 74 & 99. Please explain how the increases in population impact the development of Factor D for the renewal.
  - 75 & 100. Is the addition of new participants each year expected to change the characteristics (risk profile) of the population?
    - bb. If so, please describe how the change in the overall risk characteristics of the population affected the projection of factor D.
    - cc. If the overall risk characteristics of the population did not change, how did you assure that they did not change and that there was no effect on factor D in accordance with the increased population?
  - 76 & 101. In estimating the number of units per user, please describe any analysis done to assume that utilization will remain the same as State Fiscal Year 2015.
- Comprehensive Waiver Only
  - Please provide further explanation for the derivation and appropriateness of using an annual increase of 2.25% each year.

Development of Factors D′, G and G′ (Section J-2c)

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 77 & 103. Please provide further explanation for the derivation and appropriateness of using an annual increase of 2.25% for Factor D′, Factor G, and Factor G′.

QIS – I: Financial Accountability

Questions asked of:

- Both Adult Day and Comprehensive Waivers
  - 87 & 116. Regarding sub-assurance (a):
    - ff. How does the State ensure that claims are paid only for services rendered?
    - gg. How does the State ensure that claims are coded correctly?
    - hh. How does the State ensure that services have been actually rendered before they are paid?
    - ii. The proposed PM does not cover all aspects of the sub-assurance. Therefore the state should propose additional PMs to cover all aspects of the sub-assurance.
- Comprehensive Waiver Only
  - 117. Regarding sub-assurance (b): Please clarify how the approved service rate is assured to be developed consistent with the approved rate methodology and that the rate changes will only be made consistent with the approved rate methodology.